ILLINOIS DEPARTMENT OF Healthcare and Family Services

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INFORMATIONAL NOTICE

DATE: June 8, 2006

TO: Participating Durable Medical Equipment, Hospitals and Pharmacy Providers

RE: Power Mobility Devices and Custom Manual Wheelchairs

The purpose of this notice is to inform providers that the DPA 3701H (N-11-98), "Questionnaire For Power Equipment Wheelchair" form has been revised and is being replaced by the HFS 3701H (R-4-06) "Seating/Mobility Evaluation" form. The revised 3701H and the new HFS 3701K (N-4-06), "Power Mobility Devices (PMD) and Custom Manual Wheelchairs" form will be required by the department with requests for power mobility devices (PMD) and custom manual wheelchairs.

Effective July 1, 2006, prior approval requests for PMDs and custom manual wheelchairs must include these forms and will not be processed until all information is received from the ordering physician, a licensed physiatrist or physical/occupational therapist (chosen by the physician) and the Durable Medical Equipment (DME) provider. Information must be complete, legible, dated and signed by the appropriate provider or the request will be returned. These forms are to be used by medical providers instead of narrative letters of medical necessity; however, narrative statements must be used when comments are requested on the forms and for medical justification of requested accessories.

The department relies on DME providers to ensure that all the information required on the forms is collected from the medical providers, checked for completeness, legibility and mailed (not faxed) to the department with the order, product information and pricing. Therefore, it is recommended that DME providers forward a copy of this provider notice and the appropriate forms to the medical providers for their use. A request for additional information or a return of an incomplete or invalid request will be made to the DME provider for appropriate disposition.

The HFS 3701H and 3701K forms and information on documentation required when requesting PMDs and custom manual wheelchairs can be found on the department's Web site at:

www.hfs.illinois.gov/medicalforms/

If you have questions regarding this notice, please contact the Bureau of Comprehensive Health Services at 1-877-782-5565.

Anne Marie Murphy, Ph.D.
Administrator
Division of Medical Programs

Required Documentation for Power Mobility Devices and Custom Manual Wheelchairs Requests

The following identifies the documentation needed by the department in order to process requests for power mobility devices and custom manual wheelchairs:

Ordering Physician

- A completed HFS 3701K (N-4-06) form titled “Power Mobility Devices (PMD) and Custom Manual Wheelchairs,” after a face-to-face evaluation of the patient.
- A signed, dated order for all requested equipment, including accessories, with brief, narrative medical justification (not the function of the item) for each requested item - (documentation of medical necessity can be delegated to the evaluating physiatrist or physical/occupational therapist but must be reviewed, co-signed & dated by the ordering physician, who should indicate if he/she has any disagreement with specific findings or recommendations). The physician is responsible for arranging the physiatrist/physical/occupational therapy evaluation. The evaluator must be licensed and conduct the evaluation face to face. In those rare instances when a physiatrist or physical/ occupational therapist is not available, the physician may complete the evaluation with department approval. Multiple-paged physician orders must have either the patient’s name or the physician’s signature on each page.

Physiatrist or Physical/Occupational Therapist:

- Documentation of a face-to-face, hands-on evaluation of the patient (in association with a mobility device specialist) by a licensed physiatrist or physical/ occupational therapist (that is to be reviewed and co-signed by the ordering physician) and includes a recommendation for the optimal mobility equipment to serve the patient for the next five-to-six (5-6) years.
- A completed HFS 3701H (R-4-06) form titled “Seating/Mobility Evaluation." The therapist must complete and sign a checklist (on the form) of any affiliation with the Durable Medical Equipment provider, the manufacturer of the ordered equipment, or a long term facility that is the recipient’s residence.
- The minimum equipment to meet the patient’s needs should be recommended, cost effectiveness must be a high priority consideration and judgment must be applied to ensure that the recommended equipment can be modified to meet the changing needs of a patient who has a condition characterized by deterioration, or who is growing in stature and/or is gaining weight.

Durable Medical Equipment (DME) Provider

- Submit order on Form DPA 2240 **via mail only – faxed requests will be returned**. **Please do not enter orders for base and accessories separately in multiple boxes on the form**. When entering the order in box1 on the form, specify the HCPCS code for the wheelchair base, if wheelchair base only is ordered, or if accessories are included with the base price. If accessories are not included with the base, order as K0014 or K0009 for a power wheelchair or custom manual wheelchair respectively, and list each ordered item on a separate itemized price list.
- The DME provider’s itemized price list must include: **HCPCS code** and manufacturer’s pricing information including MSRP**, and provider’s acquisition cost (**excluding taxes and shipping**) for each requested item.** A column showing provider’s price may be included, however, HFS payment will be based upon the MSRP, the provider’s acquisition cost, or Medicare allowable. This provider’s itemized price list is separate from, and additional to, the pricing information shown on the manufacturer’s product pricing sheets that must be included with the order.
- The manufacturer’s product information including pricing, descriptions of the base and major components plus specifications showing the maximum user weight capacity,

dimensions, and seating measurements of the mobility device that has been ordered. The manufacturer's pricing information must include the MSRP, the charge to the provider (excluding taxes and shipping charges), and the HCPCS code for each ordered item and must be on the manufacturer's letterhead. If the provider is constructing a component such as a seating system, the pricing information must show a breakdown of material and labor costs.

- DME provider will check the medical providers' information for completeness and legibility and, if satisfactory, forward to HFS with the order. The order must be received by HFS within ninety (90) days of the date of the physician's order.
- A signed statement from the DME provider that states: "If prior approval is given, we will supply to the named recipient the equipment and accessories shown on the order form and the itemized price list **and this equipment meets the patient's medical need at the time of delivery**."

All the above referenced documentation is to be mailed to the following address:

Illinois Department of Healthcare and Family Services
Bureau of Comprehensive Health Services
Attn: Prior Approval Unit
P.O. Box 19124
Springfield, IL 62763-0002

POWER MOBILITY DEVICES (PMDs) AND CUSTOM MANUAL WHEELCHAIRS

(Physician Also To Sign PT/OT Evaluation – Information Must be Complete & Legible)

Patient's Name:_____RIN:_____Birth Date:_____
Physician's Name (Print): _____ State License No._____
Physician's Phone No. [_____]_____Face-to-Face Evaluation Date:_____/_____/_____

The Patient Needs: [ ] Power Wheelchair [ ] Power Scooter [ ] Custom Manual Wheelchair

ATTACH ORDER ON SEPARATE SHEET

- ♦ ***Medical Necessity Must Be Documented For Each Item Ordered (Brief Narrative Description)***
- ♦**[ ]** ***Check if Delegated To Evaluating Physiatrist or Physical/Occupational Therapist***

Patient's Diagnoses: (ICD9 Codes Optional) – Date Onset If Known: _____
_____

Describe Patient's Disabilities That Require Mobility Equipment: (*Use Quantitative Terms To Describe Effects on Mobility)*

NEURO/MUSCULO/SKELETAL: _____
_____
Date Onset_____[ ] Slowly Progressive [ ] Rapidly Progressive [ ] Stable **Requires: [ ] PMD [ ] Cust. Man.W.C.**
CARDIOVASCULAR/PULMONARY: _____
_____
Date Onset _____ [ ] Slowly Progressive [ ] Rapidly Progressive [ ] Stable **Requires:[ ] PMD [ ] Cust. Man.W.C.**
WEAKNESS: (State Etiology)_____
_____
Date Onset _____ [ ] Slowly Progressive [ ] Rapidly Progressive [ ] Stable **Requires:[ ] PMD [ ] Cust. Man.W.C.**
OTHER:_____
Date Onset_____[ ] Slowly Progressive [ ] Rapidly Progressive [ ] Stable **Requires: [ ] PMD [ ] Cust.Man.W.C.**

Patient's Potential For Improvement: [ ] None Expected [ ] Good Expected In: [ ] Months.

Has Patient Had Surgery Recently Or Is It Being Planned? [ ] No [ ] Yes If Yes: What, When,_____
What Is Expected Effect On Patient's Mobility & When Is Improvement Expected**: _____**
_____

Patient's Current Weight:_____ Lbs- Weight 1 year ago _____Lbs - Weight 2 years ago _____Lbs
Describe Growth Of Pediatric Patient Past 2- 5 Years - (Ht., Wt., & Seating Measurements - dates)
_____

The Patient Can Operate The Ordered Equipment Safely & Responsibly: [ ] Yes [ ] No
Patient Is Restricted To Operating In Home Environment Only: [ ] Yes [ ] No
Comment: _____

If A Power Wheelchair Is Ordered, Could A Power Scooter Serve The Patient's Needs? If Not, Why? _____

I the undersigned certify that the above information is true, that this patient requires the ordered equipment/accessories because of his/her documented medical condition(s), that this patient can safely & responsibly operate the equipment, and that the use of the equipment is not for the patient's convenience but is medically necessary for mobility.
I also certify with my signature on their documents that I have reviewed all information provided by the evaluating Physiatrist or Physical/Occupational Therapist and concur with or have noted my disagreements with their findings.

_____
Ordering Physician's Signature **Date**

Seating/Mobility Evaluation

To be completed by Physiatrist or Physical/Occupational Therapist

PATIENT INFORMATION:

Name:	**DOB:** **Sex:**	**Date Seen:** **Time:**
Address:	**Physician:** **Seating Therapist:** **Phone:**	***This evaluation/justification form will serve as the LMN for the following suppliers*:** _____ **Supplier:** Contact Person: Phone:
Phone:	**Primary Therapist:**	
Spouse/Parent/Caregiver Name: **Phone Number:**	**Insurance/Payer:** **Recipient #**	**Rehabilitation Engineering Program or 2nd Supplier** Contact Person: Phone :
Reason for Referral		
Patient Goals:		
Caregiver Goals and Specific Limitations that May Effect Care:		

MEDICAL HISTORY:

Diagnosis:	ICD9 Code:	**Primary Diagnosis**: **Onset:**	ICD9 Code:	Diagnosis:	
	ICD9 Code:	Diagnosis:	ICD9 Code:	Diagnosis:	
❒Progressive Disease	**Relevant Past and Future Surgeries**:				
Height:	**Weight:**	Explain Recent Changes or Trends in Weight:			
History:					
Cardio Status: Functional Limitations:					
❒Intact ❒ Impaired ❒ Severely Impaired ❒ NA					
Respiratory Status: Functional Limitations:					
❒Intact ❒Impaired ❒ Severely Impaired ❒ NA					
Orthotics: **Amputee** ❒ Yes ❒ No					

HOME ENVIRONMENT:

❒House❒ Condo/Town Home ❒Apartment ❒Asst Living ❒LTCF ❒Own ❒Rent
❒Lives Alone ❒ Lives with Others Hours with caregiver:
❒Home is Accessible to Equipment Storage of Wheelchair: ❒In Home ❒Other Stairs ❒ Yes ❒ No ***Comments:***

Patient Name:

COMMUNITY ADL:

TRANSPORTATION:

❒Car ❒Van ❒Public Transportation ❒Adapted W/C Lift ❒ Ambulance ❒Other: ❒Sits in Wheelchair During Transport

Where is W/C Stored During Transport? ❒Tie Downs

❒Self Driver Drive While in Wheelchair ❒Yes ❒No

Employment:
Specific Requirements Pertaining to Mobility

School:
Specific Requirements Pertaining to Mobility

Other:

FUNCTIONAL/SENSORY PROCESSING SKILLS:

Handedness: ❒Right ❒Left ❒NA Comments:

Functional Processing Skills for Wheeled Mobility
❒Processing Skills are Adequate for Safe Wheelchair Operation
Comments:

COMMUNICATION:

Verbal Communication ❒WFL Receptive ❒ WFL Expressive ❒Understandable ❒Difficult to Understand ❒Non-Communicative
❒Uses an Augmentative Communication Device Manufacturer/Model :

AAC Mount Needed:

SENSATION and SKIN ISSUES:

Sensation
❒Intact ❒Impaired ❒Absent
❒Hyposensate ❒Hypersensate
❒Defensiveness
Level of sensation:

Pressure Relief:
Able to Perform Effective Pressure Relief : ❒Yes ❒ No
Method:
If not, Why?:

Skin Issues/Skin Integrity
Current Skin Issues ❒Yes ❒No
❒Intact ❒ Red Area❒ Open Area
❒Scar Tissue ❒At Risk from Prolonged Sitting
Where _____

History of Skin Issues ❒Yes ❒No
Where _____
When _____

Hx of Skin Flap Surgeries ❒Yes ❒No
Where _____
When _____

Complaint of Pain: Please Describe

ADL STATUS (In Reference to Wheelchair Use):

	Indep	Assist	Unable	Indep with Equip	Not Assessed	Comments
Dressing						
Eating						Describe Oral Motor Skills
Grooming/Hygiene						
Meal Prep						
IADLS						
Bowel Mngmnt: ❒Continent ❒Incontinent ❒Accidents						Comments:
Bladder Mngmnt: ❒Continent ❒Incontinent ❒Accidents						Comments:

Patient Name:

CURRENT SEATING / MOBILITY:

Current Mobility Base: ❒None ❒Dependent ❒Dependent with Tilt ❒Manual ❒Scooter ❒Power Type of Control:
Manufacturer: Model: Serial #:
Size: Color: Age:

Current Condition of Mobility Base:

Current Seating System: Age of Seating System:

COMPONENT	MANUFACTURER/CONDITION
Seat Base	
Cushion	
Back	
Lateral Trunk Supports	
Thigh Support	
Knee Support	
Foot Support	
Foot Strap	
Head Support	
Pelvic Stabilization	
Anterior Chest/Shoulder Support	
UE Support	
Other	
When Relevant:	Overall Seat Height Overall W/C Length Overall W/C Width

Describe Posture in Present Seating System:

WHEELCHAIR SKILLS: (Shown by Trial)

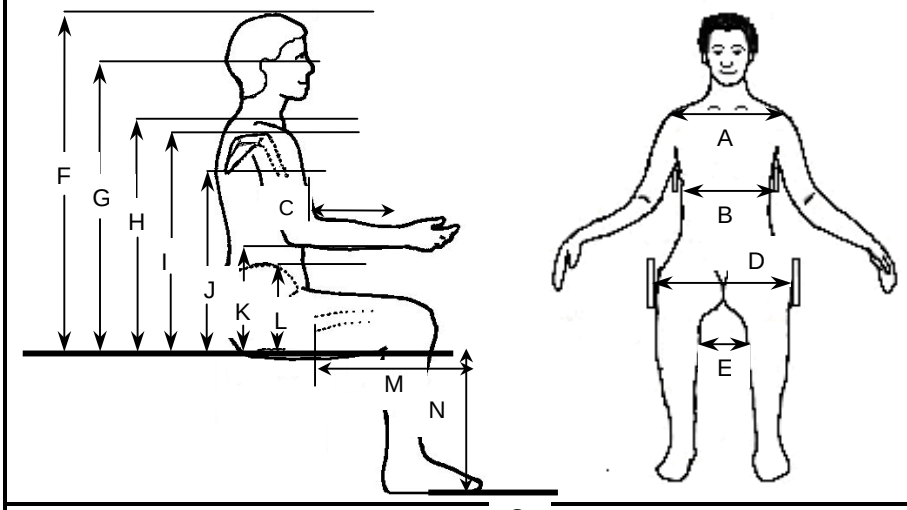
	Indep	Assist	Dependent/ Unable	N/A	Comments
Bed ↔ W/C Chair Transfers	❒	❒	❒	❒	
w/c ↔ Commode Transfers	❒	❒	❒	❒	
Manual w/c Propulsion:	❒ UE or LE Strength and Endurance Sufficient to Participate in ADLs Using Manual Wheelchair				Arm : ❒Left ❒Right ❒Both Foot: ❒Left ❒Right ❒Both
Operate Scooter	❒ Strength, Hand Grip, Balance , Transfer Appropriate for Use. ❒ Living Environment Appropriate for Scooter Use.				
Operate Power W/C: Std. Joystick	❒	❒	❒	❒	❒Safe ❒ Functional Distance
Operate Power W/C: w/ Alternative Controls	❒	❒	❒	❒	❒Safe ❒ Functional Distance

MOBILITY/BALANCE:

Balance		Transfers	Ambulation
Sitting Balance:	Standing Balance	❒ Independent	❒ Independent
❒ WFL	❒ WFL	❒ Min Assist	❒ Ambulates with Asst
❒Uses UE for Balance in Sitting	❒Min Assist	❒ Mod Asst	❒ Ambulates with Device
❒ Min Assist	❒ Mod Assist	❒Max Assist	❒ Indep. Short Distance Only
❒ Mod Assist	❒Max Assist	❒ Dependent	❒ Unable to Ambulate
❒Max Assist	❒ Unable	❒ Sliding Board	
❒ Unable		❒ Lift / Sling Required	
Comments:			

Patient Name:

MAT EVALUATION:



	Measurements in Sitting:	Left	Right		
	A: Shoulder Width				
	B: Chest Width			**H:**	Seat to Top of Shoulder
	C: Chest Depth (Front – Back)			**I:**	Acromium Process (Tip of Shoulder)
	D. Hip width			**J:**	Inferior Angle of Scapula
	E. Between Knees			**K:**	Seat to Elbow
	F. Top of Head			**L:**	Seat to Iliac Crest
	G. Occiput			**M:**	Upper leg length
	++ Overall width (asymmetrical width for windswept legs or scoliotic posture			**N:**	Lower leg length
				O:	Foot Length

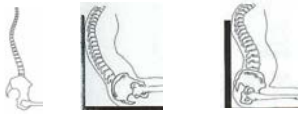
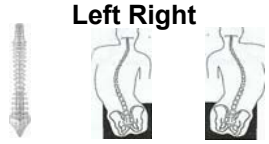
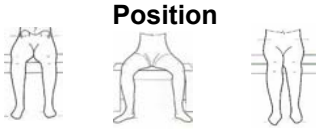
Additional Comments:

Hamstring flexibility: Pelvis to thigh angle ❒accommodate greater than 90 **Thigh to calf angle** ❒ accommodate less than 90

DESCRIBE REFLEXES/TONAL INFLUENCE ON BODY:

EXPLAIN WHY PATIENT IS NON-AMBULATORY:

Patient Name:

POSTURE:				COMMENTS:
PELVIS	**Anterior / Posterior**  ❒ Neutral ❒ Posterior ❒ Anterior ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	**Obliquity**  ❒ WFL ❒ R elev ❒ l elev ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	**Rotation-Pelvis**  ❒ WFL ❒ Right Anterior ❒ Left Anterior ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	
TRUNK	**Anterior / Posterior**  ❒ WFL ❒ ↑ Thoracic Kyphosis ❒ ↑ Lumbar Lordosis ❒ Fixed ❒ Flexible ❒ Partly Flexible ❒ Other	**Left Right**  ❒ WFL ❒ Convex Left ❒ Convex Right ❒c-curve ❒s-curve ❒multiple ❒ Fixed ❒ Flexible ❒ Partly Flexible ❒ Other	**Rotation-shoulders and upper trunk**  ❒ Neutral ❒ Left-anterior ❒ Right-anterior ❒ Fixed ❒ Flexible ❒ Partly Flexible ❒ Other	
	Describe LE Neurological Influence/Tone:			
HIPS	**Position**  ❒ Neutral ❒ ABduct ❒ ADduct ❒ Fixed ❒ Subluxed ❒ Partly Flexible ❒ Dislocated ❒ Flexible	**Windswept**  ❒ Neutral ❒ Right ❒ Left ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	**Hip Flexion/Extension Limitations:** **Hip Internal/External Range of motion Limitations:**	
KNEES & FEET	**Knee R.O.M.** Left ❒ WFL ❒Limitations Right ❒ WFL ❒Limitations		**Foot Positioning** ❒ WFL ❒L ❒R ROM concerns: Dorsi-Flexed ❒L ❒R Plantar Flexed ❒L ❒R Inversion ❒L ❒R Eversion ❒L ❒R	

Patient Name:

POSTURE:				COMMENTS:
HEAD & NECK	❒ Functional ❒ Flexed ❒ Extended ❒ Rotated L ❒ Lat Flexed L ❒ Rotated R ❒ Lat Flexed R ❒ Cervical Hyperextension	❒ Good Head Control ❒ Adequate Head Control ❒ Limited Head Control ❒ Absent Head Control	**Describe Tone/Movement of head and Neck:**	
UPPER EXTREMITY	**SHOULDERS** **Left** **Right** ❒Functional ❒Functional ❒elev / dep ❒elev / dep ❒pro-retract ❒pro-retract ❒subluxed ❒subluxed	**R.O.M. for Upper Extremity** ❒WNL ❒WFL Limitations: **UE Strength (X/5):** ❒ **N/A** ❒ **None** ❒**Concerns:**	**Describe Tone/Movement of UE:**	
	ELBOWS **Left** **Right**	**R.O.M.** **Strength (X/5)** **Strength concerns:**		
WRIST & HAND	**Left** **Right** ❒Fisting	**Strength / Dexterity: (X/5)**		

Goals for Wheelchair Mobility

- ❒ Independence with mobility in the home and motor related ADLs (MRADLs) in the community
- ❒ Independence with MRADLs in the community
- ❒ Provide dependent mobility
- ❒ Provide recline
- ❒Provide tilt ❒

Goals for Seating system

- ❒ Optimize pressure distribution
- ❒ Provide support needed to facilitate function or safety
- ❒ Provide corrective forces to assist with maintaining or improving posture
- ❒ Accommodate client's posture: current seated postures and positions are not flexible or wilnot tolerate corrective forces
- ❒ Client to be independent with relieving pressure in the wheelchair
- ❒Enhance physiological function such as breathing, swallowing, digestion

Equipment trials:

State why other equipment was unsuccessful:

Patient Name:

MOBILITY BASE RECOMMENDATIONS and JUSTIFICATION

MOBILITY BASE	JUSTIFICATION	
Manufacturer: **Model:** **Color:** Size: Width Seat Depth	❒provide transport from point A to B ❒promote Indep mobility ❒is not a safe, functional ambulator ❒walker or cane inadequate	❒non-standard width/depth necessary to accommodate anatomical measurement ❒
❒**Manual Mobility Base**	❒non-functional ambulator	
❒**Scooter/POV**	❒can safely operate ❒can safely transfer	❒has adequate trunk stability ❒can not functionally propel manual wheelchair
❒**Power Mobility Base**	❒non-ambulatory ❒can not functionally propel manual wheelchair	❒ can not functionally and safely operate scooter/POV
❒**Stroller Base**	❒infant/child ❒unable to propel manual wheelchair ❒allows for growth	❒non-functional ambulator ❒non-functional UE ❒ Indep mobility is not a goal at this time
Tilt Base or added ❒Forward ❒Backward ❒Powered tilt on powered chair ❒Powered tilt on manual chair ❒Manual tilt on manual base	❒ change position against gravitational force on head and shoulders ❒change position for pressure relief/can not weight shift ❒transfers	❒management of tone ❒rest periods ❒control edema ❒facilitate postural control ❒
Recline ❒Power recline on power base ❒Manual recline on manual base	❒ accommodate femur to back angle ❒ bring to full recline for ADL care ❒ change position for pressure relief/can not weight shift	❒rest periods ❒repositioning for transfers or clothing/diaper /catheter changes ❒head positioning
❒**Transportation tie-down option**	❒to provide crash tested tie down brackets	
Elevator on Mobility Base ❒Wheelchair ❒Scooter	❒increase Indep in transfers ❒increase Indep in ADLs	❒raise height for communication at standing level ❒
Push handles ❒extended ❒angle adjustable ❒standard	❒caregiver access ❒caregiver assist	❒allows “hooking” to enable increased ability to perform ADLs or maintain balance
Lighter weight required	❒self propulsion ❒lifting	❒
Heavy Duty required	❒user weight greater than 250 pounds ❒extreme tone ❒over active movement	❒broken frame on previous chair ❒multiple seat functions ❒
Specific seat height required Floor to seat height	❒foot propulsion ❒transfers ❒accommodation of leg length	❒access to table or desk top ❒
Rear wheel placement/Axle adjustability ❒None ❒semi adjustable ❒fully adjustable	❒improved UE access to wheels ❒improved stability ❒changing angle in space for improvement of postural stability	❒1-arm drive access ❒amputee placement ❒

Patient Name:

MOBILITY BASE	JUSTIFICATION	
Angle Adjustable Back	❒postural control ❒control of tone/spasticity ❒accommodation of range of motion	❒UE functional control ❒accommodation for seating system ❒
POWER WHEELCHAIR CONTROLS ❒**Proportional** Type Body Parts Left Right ❒**Non-Proportional/switches** Type Body Parts **Upgraded Electronics** ❒ ❒**Display box** ❒Digital interface electronics ❒ASL Head Array ❒**Sip and puff tubing kit** ❒Upgraded tracking electronics ❒**Safety Reset Switches** ❒Single or Multiple Actuator Control Module	❒provides access for controlling wheelchair ❒ lacks motor control to operate proportional drive control ❒ unable to understand proportional controls ❒programming for accurate control ❒progressive Disease/changing condition ❒Needed in order to operate power/tilt through joystick control ❒Allows user to see in which mode and drive the wheelchair is set; necessary for alternate controls ❒Allows w/c to operate when using alternative drive controls ❒Allows client to operate wheelchair through switches placed in tri-panel headrest ❒needed to operate sip and puff drive controls ❒increase safety when driving ❒ correct tracking when on uneven surfaces ❒Used to change modes and stop the wheelchair when driving in latch mode ❒ Allow the client to operate the power seat function(s) through the joystick control	❒non-proportional drive control needed
❒Mount for switches or joystick	❒Attaches switches to w/c ❒Swing away for access or transfers	❒midline for optimal placement ❒provides for consistent access
Attendant controlled joystick plus mount	❒safety ❒long distance driving ❒operation of seat functions	❒compliance with transportation regulations ❒
Battery	❒power motor on wheelchair	

Patient Name:

MOBILITY BASE	JUSTIFICATION	
Charger	❒charge battery for wheelchair	
Push rim active assist	❒enable propulsion of manual wheelchair on sloped terrain	❒enable propulsion of manual wheelchair for distance
Hangers/ Leg rests ❒60 ❒70 ❒90 ❒elevating ❒heavy duty ❒articulating ❒fixed ❒lift off ❒swing away ❒rotational hanger brackets ❒adjustable knee angle ❒adjustable calf panel ❒ Longer extension tube	❒provide LE support ❒accommodate to hamstring tightness ❒elevate legs during recline ❒provide change in position for Les ❒Maintain placement of feet on footplate	❒durability ❒enable transfers ❒decrease edema ❒Accommodate lower leg length ❒
Foot support ❒adjustable Footplate ❒R ❒L ❒flip up ❒depth/angle adjustable	❒provide foot support ❒accommodate to ankle ROM ❒allow foot to go under wheelchair base	❒transfers ❒
Armrests ❒fixed ❒adjustable height ❒removable ❒swing away ❒flip back ❒reclining ❒full length pads ❒desk ❒pads tubular	❒provide support with elbow at 90 ❒provide support for w/c tray ❒change of height/angles for variable activities	❒remove for transfers ❒allow to come closer to table top ❒remove for access to tables ❒
Side guards	❒prevent clothing getting caught in wheel or becoming soiled	
Wheel size: **Wheel Style** ❒mag ❒spokes ❒	❒increase access to wheel ❒allow for seating system to fit on base	❒increase propulsion ability ❒maintenance ❒
Quick Release Wheels	❒allows wheels to be removed to decrease width of w/c for storage	❒decrease weight for lifting ❒
Wheel rims/ hand rims ❒metal ❒plastic coated ❒vertical projections ❒oblique projections	❒ Provide ability to propel manual wheelchair	❒ Increase self-propulsion with hand weakness/decreased grasp
Tires: ❒pneumatic ❒flat free inserts ❒solid	❒decrease maintenance ❒prevent frequent flats ❒increase shock absorbency	❒decrease pain from road shock ❒decrease spasms from road shock ❒
Caster housing: **Caster size:** **Style:**	❒maneuverability ❒stability of wheelchair ❒increase shock absorbency ❒durability ❒maintenance ❒angle adjustment for posture	❒decrease pain from road shock ❒decrease spasms from road shock ❒allow for feet to come under wheelchair base ❒allows change in seat to floor height ❒
Shock absorbers	❒ decrease vibration	❒ provide smoother ride over rough terrain
Spoke Protector	❒ prevent hands from getting caught in spokes	❒
One armed device ❒Left ❒Right	❒enable propulsion of manual wheelchair with one arm	❒
Anti-tippers	❒prevent wheelchair from tipping backward	❒
Amputee adapter	❒Provide support for stump/residual extremity	
❒ Crutch/cane holder **❒ Cylinder holder** **❒ IV hanger**	❒Stabilize accessory on wheelchair	

Brake/wheel lock extension ❒R ❒L		❒increase indep in applying wheel locks
Other:		
Other:		

SEATING COMPONENT RECOMMENDATIONS AND JUSTIFICATION

Component	Manuf/mod/size	Justification	
Seat Cushion		❒accommodate impaired sensation ❒decubitus ulcers present ❒prevent pelvic extension ❒low maintenance	❒stabilize pelvis ❒accommodate obliquity ❒accommodate multiple deformity ❒neutralize LE ❒increase pressure distribution ❒
Seat Wedge		❒accommodate ROM	❒Provide increased aggressiveness of seat shape to decrease sliding down in the seat
Cover Replacement		❒protect back or seat cushion	❒
Mounting hardware lateral trunk supports headrest medial thigh support back seat	fixed swing away for:	❒attach seat platform/cushion to w/c frame ❒attach back cushion to w/c frame	❒mount headrest ❒swing medial thigh support away ❒swing lateral supports away for transfers
Seat Board **Back Board**		❒support cushion to prevent hammocking	❒ allows attachment of cushion to mobility base
Back		❒provide lateral trunk support ❒accommodate deformity ❒accommodate or decrease tone ❒facilitate tone	❒provide posterior trunk support ❒provide lumbar/sacral support ❒support trunk in midline ❒
Lateral pelvic/thigh support		❒ pelvis in neutral ❒accommodate pelvis ❒position upper legs	❒accommodate tone ❒removable for transfers ❒
Medial Knee Support		❒decrease adduction ❒accommodate ROM	❒remove for transfers ❒alignment
Foot Support		❒position foot ❒accommodate deformity	❒stability ❒decrease tone ❒control position
Ankle strap/heel loops		❒support foot on foot support ❒decrease extraneous movement	❒provide input to heel ❒protect foot
Lateral trunk Supports	❒R ❒L	❒decrease lateral trunk leaning ❒accom asymmetry ❒contour for increased contact	❒safety ❒control of tone ❒
Anterior chest strap, vest, or shoulder retractors		❒decrease forward movement of shoulder ❒accommodation of TLSO decrease forward movement of trunk	❒added abdominal support ❒alignment ❒assistance with shoulder control ❒decrease shoulder elevation ❒

Patient Name:

Component	Manuf/mod/size	Justification	
Headrest		❒provide posterior head support ❒provide posterior neck support ❒provide lateral head support ❒provide anterior head support ❒support during tilt and recline ❒improve feeding	❒improve respiration ❒placement of switches ❒safety ❒accommodate ROM ❒accommodate tone ❒improve visual orientation
Neck Support		❒decrease neck rotation	❒decrease forward neck flexion
Upper Extremity Support Arm trough Posterior hand support ½ tray full tray swivel mount	❒R ❒L	❒decrease edema ❒decrease subluxation ❒control tone ❒provide work surface ❒placement for AAC/Computer/EADL	❒decrease gravitational pull on shoulders ❒provide midline positioning ❒provide support to increase UE function ❒provide hand support in natural position
Pelvic Positioner Belt SubASIS bar Dual Pull		❒stabilize tone ❒decrease falling out of chair/ **will not decrease potential for sliding due to pelvic tilting ❒prevent excessive rotation	❒pad for protection over boney prominence ❒prominence comfort ❒special pull angle to control rotation ❒
Bag or pouch		**Holds:** ❒medicines ❒special food ❒orthotics ❒clothing changes	❒diapers ❒catheter/hygiene ❒ostomy supplies ❒
Other			

Patient/Client/Caregiver Signature:		**Date:**
Therapist Name Printed:		
Therapist's Signature		**Date:**
Supplier's Name Printed:		
Supplier's Signature:		**Date:**

I agree with the above findings and recommendations of the therapist and supplier:

Physician's Name Printed:		
Physician's Signature:		**Date:**

This is to certify that I, the above signed therapist have the following affiliations:

❒ This DME Provider
❒ Manufacturer of Recommended Equipment
❒ Patient's Long Term Care Facility
❒ None of the above